

§ 424.50

effective date of their Medicare billing privileges:

- (1) Physician or nonphysician practitioner organizations.
- (2) Physicians.
- (3) Nonphysician practitioners.
- (4) Independent diagnostic testing facilities.

[53 FR 6634, Mar. 2, 1988, as amended at 65 FR 83153, Dec. 29, 2000; 73 FR 69939, Nov. 19, 2008; 75 FR 73627, Nov. 29, 2010]

Subpart D—To Whom Payment Is Ordinarily Made

§ 424.50 Scope.

(a) This subpart specifies to whom Medicare payment is ordinarily made for different kinds of services.

(b) Subpart E of this part sets forth provisions applicable in special situations.

(c) Subpart F of this part specifies the exceptional circumstances under which payment may be made to an assignee or reassignee.

§ 424.51 Payment to the provider.

(a) *Basic rule.* Except as specified in paragraph (b) of this section, Medicare pays the provider for services furnished by a provider.

(b) *Exception.* Medicare pays the beneficiary for outpatient hospital services if the hospital has collected an amount in excess of the unmet deductible and coinsurance, as specified in § 489.30(b)(4) of this chapter.

§ 424.52 Payment to a nonparticipating hospital.

Medicare pays a nonparticipating hospital for the following services, if covered, in the specified circumstances:

(a) Emergency inpatient and outpatient services furnished by a U.S. hospital, if the hospital has in effect an election to claim payment in accordance with subpart G of this part.

(b) Certain medical and other health services covered under Medicare Part B and furnished by a U.S. hospital, if the hospital meets the requirements of § 424.55 for payment as a supplier.

(c) Emergency or nonemergency inpatient services furnished by a foreign hospital if the hospital has in effect an

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election to claim payment in accordance with subpart G of this part.

§ 424.53 Payment to the beneficiary.

Medicare pays the beneficiary for the following services, if covered, in the specified circumstances:

(a) Emergency inpatient and outpatient services furnished by a nonparticipating U.S. hospital that has not elected to claim payment in accordance with subpart G of this part.

(b) Certain medical and other health services covered under Medicare Part B and furnished by a nonparticipating U.S. hospital, if the hospital does not receive assigned payment as a supplier under § 424.55.

(c) Emergency or nonemergency services furnished by a foreign hospital if the hospital does not have in effect an election to claim payment in accordance with subpart H of this part.

(d) Physician and ambulance services furnished outside the United States.

(e) Services furnished by a supplier if the claim has not been assigned to the supplier.

§ 424.54 Payment to the beneficiary's legal guardian or representative payee.

Medicare may pay amounts due a beneficiary to the beneficiary's legal guardian or representative payee.

§ 424.55 Payment to the supplier.

(a) Medicare pays the supplier for covered services if the beneficiary (or the person authorized to request payment on the beneficiary's behalf) assigns the claim to the supplier and the supplier accepts assignment.

(b) In accepting assignment, the supplier agrees to the following:

(1) To accept, as full charge for the service, the amount approved by the carrier as the basis for determining the Medicare Part B payment (the reasonable charge or the lesser of the fee schedule amount and the actual charge).

(2) To limit charges to the beneficiary or any other source as follows:

(i) To collect nothing for those services for which Medicare pays 100 percent of the Medicare approved amount.

(ii) To collect only the difference between the Medicare approved amount

and the Medicare Part B payment (for example, the amount of any reduction in incurred expenses under § 410.155(c), any applicable deductible amount, and any applicable coinsurance amount) for services for which Medicare pays less than 100 percent of the approved amount.

(3) Not to charge the beneficiary when Medicare paid for services determined to be “not reasonable or necessary” if—

(i) The beneficiary was without fault in the overpayment; and

(ii) The determination that the payment was incorrect was made by the carrier after the third year following the year in which the carrier sent notice to the beneficiary that it approved the payment.

(c) *Exception.* In situations when payment under the Act can only be made on an assignment-related basis or when payment is for services furnished by a participating physician or supplier, the beneficiary (or the person authorized to request payment on the beneficiary's behalf) is not required to assign the claim to the supplier in order for an assignment to be effective.

[53 FR 6634, Mar. 2, 1988, as amended at 63 FR 20130, Apr. 23, 1998; 69 FR 66426, Nov. 15, 2004]

§ 424.56 Payment to a beneficiary and to a supplier.

(a) *Conditions for split payment.* If the beneficiary assigns the claim after paying part of the bill, payment may be made partly to the beneficiary and partly to the supplier.

(b) *Payment to the supplier.* Payment to the supplier who submits the assigned claim is for whichever of the following amounts is less:

(1) The reasonable charge minus the amount the beneficiary had already paid to the supplier; or

(2) The full Part B benefit due for the services furnished.

(c) *Payment to the beneficiary.* Any part of the Part B benefit which, on the basis of paragraph (b) of this section, is not payable to the supplier, is paid to the beneficiary.

(d) *Examples.*

Example 1. An assigned bill of \$300 on which partial payment of \$100 has been made is submitted to the carrier. The carrier determines that \$300 is the reasonable charge for the

service furnished. Total payment due is 80 percent of \$300 or \$240. Of this amount, \$200 (the difference between the \$100 partial payment and the \$300 reasonable charge) is paid to the supplier. The remaining \$40 is paid to the beneficiary.

Example 2. An assigned bill of \$325 on which partial payment of \$275 has been made is submitted to the carrier. The carrier determines that \$275 is the reasonable charge for the services. Total payment due is 80 percent of \$275 or \$220. The \$220 is paid to the beneficiary, since any payment to the supplier, when added to the \$275 partial payment would exceed the reasonable charge for the services furnished.

[53 FR 6641, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988]

§ 424.57 Special payment rules for items furnished by DMEPOS suppliers and issuance of DMEPOS supplier billing privileges.

(a) *Definitions.* As used in this section, the following definitions apply:

Accredited DMEPOS suppliers means suppliers that have been accredited by a recognized independent accreditation organization approved by CMS in accordance with the requirements at § 424.58.

Affiliate means a person or organization that is related to another person or organization through a compensation arrangement or ownership.

Assessment means a sum certain that CMS or the Office of Inspector General (OIG) may assess against a DMEPOS supplier under Titles XI, XVIII, or XXI of the Social Security Act or as specified in this chapter.

Attended facility-based polysomnogram means a comprehensive diagnostic sleep test including at least electroencephalography, electro-oculography, electromyography, heart rate or electrocardiography, airflow, breathing effort, and arterial oxygen saturation furnished in a sleep laboratory facility in which a technologist supervises the recording during sleep time and has the ability to intervene if needed.

Authorized surety means a surety that has been issued a Certificate of Authority by the U.S. Department of the Treasury as an acceptable surety on Federal bonds and the certificate has neither expired nor been revoked.

Civil money penalty (CMP) means a sum that CMS has the authority, as